ULSTER COUNTY BOARD OF HEALTH

January 9, 2012

AGENDA

CALL TO ORDER

- **OLD BUSINESS**
  a. Approval of November 14, 2011 and December 12, 2011 minutes
  b. Approval of the Ulster County Sanitary Code

- **NEW BUSINESS**

  a. Director's Report:
    - UCDOH/DMH Co-Location Update
    - Board of Health Meeting Schedule
    - Board of Health Vacancies

  b. Medical Examiner Report:
    - December Case 2011

  c. Patient Services
    - Provider Solution Article 28 Records Review on 12/21

  d. Environmental Health Report:
    - Enforcement Hearing Update
    - Program Overview: Mobile Home Parks

MEETING CONCLUSION

Ulster County Board of Health
Date: Monday, January 9, 2012

Board Members		Signature
Authenrieth RN, Joan	Vice Chairman	[signature]
Delma MD, Dominique	Secretary	[signature]
Hildebrandt, Mary Ann	Member	[signature]
Tack DO, Marc	Chairman	[signature]
Board Member	Vacant	
Board Member	Vacant	
Board Member	Vacant	

Department of Health		Signature
Gifford, Erica	Environmental Health Director	[signature]
Hasbrouck MD, MPH, LaMar	Public Health Director	[signature]
Heller MD, Douglas	Medical Examiner	Excused
Veytia RN, MSN, Nereida	Patient Services Director	[signature]

Guests		Signature
Qamar, Cheryl	UC Depart of MH Deputy Commissioner	[signature]
Cane, Lee	Mid-Hudson League of Women Voters	[signature]

Ulster County Board of Health
January 9, 2011

Members PRESENT: Joan Authenrieth, RN, Vice Chairman
Marc Tack DO, Chairman
Dominique Delma, MD, Secretary
Mary Ann Hildebrandt, Board Member

UCDOH PRESENT: LaMar Hasbrouck, MD, MPH, Public Health Director
Erica Gifford, PE, Environmental Health Services Director
Nereida Veytia, Patient Services Director

GUESTS: Cheryl Qamar, UC Department of Mental Health Deputy Commissioner
Lee Cane, Mid-Hudson League of Women Voters

ABSENT:

EXCUSED: Douglas Heller, MD, Medical Examiner

I. **Approval of Minutes:** A motion was made by Mary Ann Hildebrandt to approve the November and December minutes. The motion was seconded by Joan Authenrieth and unanimously approved.

II. **Moment of Silence:** The Board took a moment of silence in remembrance of Dr. MacFadden, Ulster County pediatrician and former Board of Health member.

III. **Old Business:**
- **Ulster County Sanitary Code:** The vote for approval of the Ulster County Sanitary Code was conducted via email and unanimously approved.

IV. **Agency Reports:**

a. Director's Update:
Dr. Hasbrouck reported on the following:

- **UCDOH/DMH Co-Location Update:** UCDOH is in the process of space planning to relocate UCDOH employees at the Flatbush site to the Golden Hill site. Blocks of space in the Mental Health building are being identified and repurposed to accommodate the approximately, 55 UCDOH employees being moved. Dr. Hasbrouck's team has been tasked with identifying their individual division's needs such as renovations, space accommodations, and program specific requirements. Once space needs have been identified, a meeting with Buildings and Grounds and Information Services will be scheduled to review. The tentative plan is to move a UCDOH team each week in March, with the move being complete by the first week in April.
- **Board of Health Meeting Schedule:** Board of Health monthly meetings will be relocated to the Golden Hill site once the relocation is complete. Dr. Hasbrouck suggested that the Board of Health meeting time is changed from 7:00 pm to 6:30 pm to reduce the time gap between the Mental Health Board meeting and the DOH Board meeting, in which members from both departments participate in. The Board voted and approved the meeting time changed once the relocation is complete.

- **Board of Health Vacancies**: Currently there are 3 vacancies. Dr. Hasbrouck has been in contact with the County Executive's office regarding succession planning for these vacancies. Dr. Hasbrouck will nominate Partner in Public Health Council members. He also encouraged Board members to submit nominations to his office. All nominations will be forwarded to the County Executive's office for consideration.

b. Medical Examiner:

- In December, there were (34) calls received. Of them, there were (6) site visits, (1) suicide, (1) homicide, (1) motor vehicle accident and (11) autopsies.
- A summary sheet of the 2011 activity of the Medical Examiner's Office was distributed. In 2011, there were (285) calls received, (112) autopsies, and (51) site visits.

c. Patient Services:
Ms. Veytia reported on the following:

- **Provider Solution Article 28 Records Review:** This review was conducted on 12/21/2011 and reviewed random records in the STD, Immunization, TB and WIC clinics. There were no significant inefficiencies noted (see attached.)
- **Medical Reserve Corps:** The MRC makes use of the ServeNY web data base which houses volunteer information who would like to be part of MRC implementation when needed. Use of this database is currently being reviewed by the County Attorney's office as there is some concern about County liability.

d. Environmental Health:
Ms. Gifford reported on the following:

- **Enforcement Overview:** A summary sheet was distributed to the Board, outlining the informal and formal hearing activities of the department (see attached.)
- **Mobile Home Park Program:** An overview of the mobile home park program was presented to the Board, outlining the permitting process, number of facilities permitted, and inspection criteria (see attached.)
- **Bed Bugs:** There was a brief discussion about bed bugs. Ms. Gifford reviewed the department's protocol. Her division will be participating in a webinar being offered by the Environmental Protection Agency and would like to host a departmental in service for staff to expand their knowledge.

Next Meeting: The next meeting is scheduled for February 13, 2012.

Adjournment: A motion was made to adjourn the meeting by Dr. Tack, seconded by Joan Authenrieth and unanimously approved.

Respectfully submitted by:

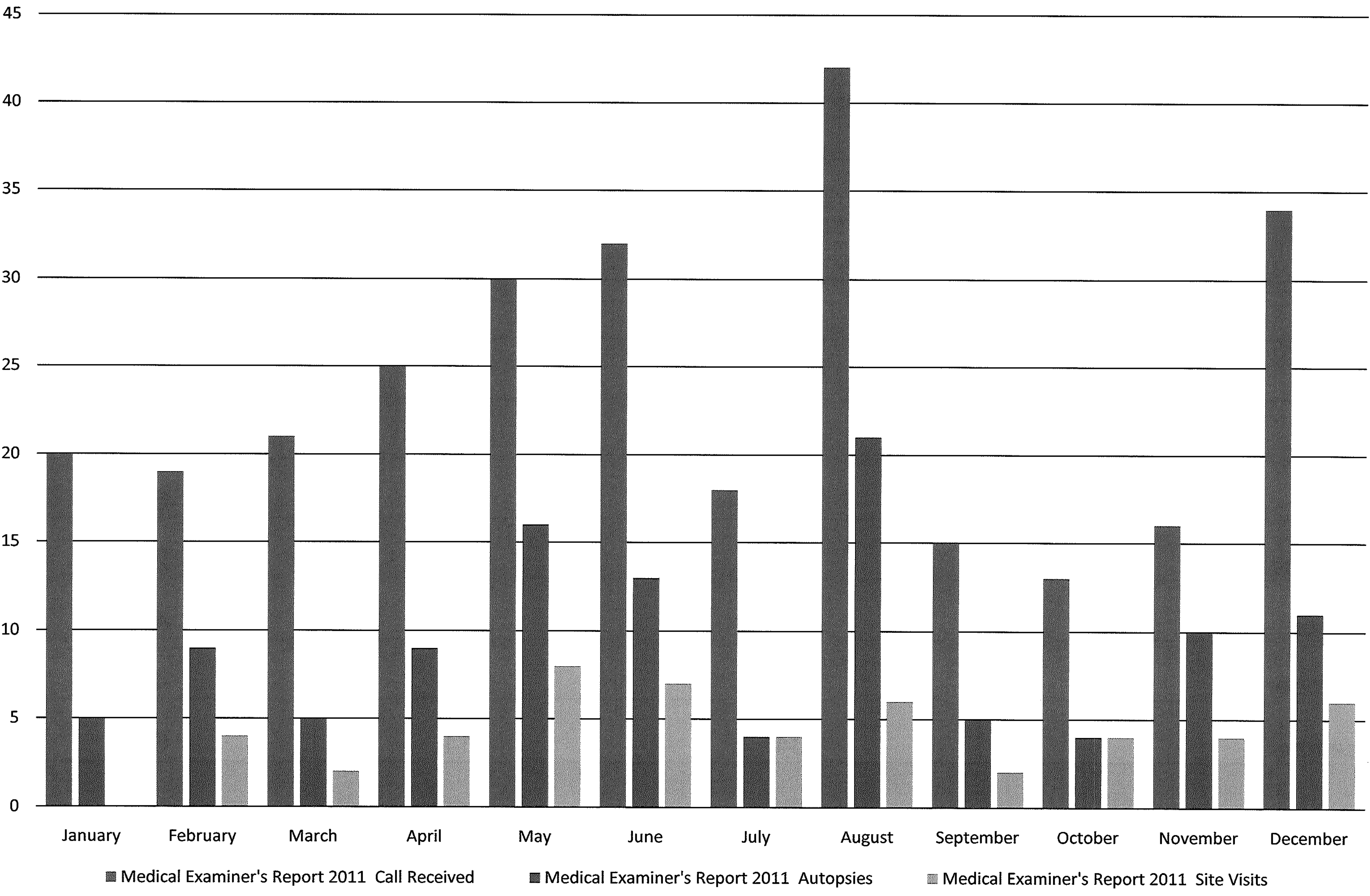
Katrina Kouhout
Secretary to the Public Health Director
On behalf of UC Board of Health

Board of Health Members						
Member	**Credentials**	**Date of Appointment**	**Length of Term**	**End of Term**	**Vacant**	**Notes**
Authenrieth, Joan	RN	7/9/2009	3 years	12/31/2012		
Delma, Dominique	MD	7/9/2009	4 years	12/31/2013		
Godfrey, Ivan	PhD	11/01/2010	1 year, 1 month	12/31/2011	Yes	Completed Marion Ostrander's Term
Hildebrandt, Mary Ann	MPA	3/1/2011	5 years	2/29/2016		David Clegg's Term ended 12/31/10
Member			5 years		Yes	Dr. MacFadden's term ended 12/31/10
Stellato, Thomas	MD	7/9/2009	2 years	12/31/2011	Yes	
Tack, Marc	MD	7/9/2009	5 years	12/31/2014		

According to the Charter:

- The Board of Health shall have 7 members
  - 2 Physicians
  - 1 Licensed health care professional who is not a physician
  - 1 member shall be selected from among 3 nominees submitted to the CE by the Mayor of Kingston
- All future terms will be 5 years. However, if a vacancy shall occur other than by expiration term, it shall be filled by appointment for the unexpired term
- No member shall serve more than 2 consecutive terms

Created 1/9/2012


Ulster County Medical Examiner
2011
45
40
35
30
25
20
15
10
5
0
January
February
March
April
May
June
July
August
September
October
November
December
Medical Examiner's Report 2011 Call Received
Medical Examiner's Report 2011 Autopsies
Medical Examiner's Report 2011 Site Visits

3 Corporate Drive, Suite 102
Clifton Park, NY 12065
(518) 371-3036 Phone
(518) 935-9174 Fax
http://www.providercs.com

December 23, 2011

La Mar Hasbrouck, MD, MPH
Public Health Director
Ulster County Health Department
300 Flatbush Avenue
Kingston, New York 12401

Re: Medical Record Review

Dear Dr. Hasbrouck:

Provider Consulting Solutions, Inc. ("PCS") was engaged by Ulster County Health Department ("Ulster County") to perform a review of medical record practices for four clinics which include Communicable Diseases, Immunizations, WIC and Tuberculosis. In accordance with NYS Medical Record Systems Regulations - 10NYCRR, 751.7(b), 10NYSCRR 405.7(b)(24), and the Health Insurance Portability and Accountability Act, PCS was asked to evaluate the quality of Ulster County's medical record documentation and to assess the manner in which medical records are initiated, completed and stored.

EXECUTIVE SUMMARY

The PCS reviewer was on-site on December 21, 2011 to review policy and procedure manuals and perform a medical record review. Overall there are no major policy revisions that were noted to be necessary at that time.

Summary audit finding by clinic are included in Appendix A. Appendices B-E provides the case specific findings by clinic. There is a patient identification key for Appendices B-E which will be provided on a separate tab.

KEY FINDINGS:

The medical record is the most important business and legal record for a healthcare organization. Its creation and maintenance are governed by regulation and well established medical record standards.

- In a few cases the reviewer noted that errors in medical record documentation were not corrected according to established paper medical record standards and Ulster County Health Department policy.

- In a few cases the author of the medical record documentation simply initialed or did not sign or completely date the note.

- Form templates are used by staff to help assure complete documentation. The reviewer found in the TB Clinic Individual Data Base form that the Current Medication section was blank. I suspect denoting that the patient did not take other drugs prior to the initiation of treatment. However on the date the form was completed the patient had started INH treatment for latent tuberculosis. If an area of the form is not completed the reviewer is unable to determine if it is not applicable to the patient or if the question was not addressed with the patient.

RECOMMENDATIONS:

- Provide annual documentation refresher training for staff regarding the appropriate method to correct an error, amend or addend a medical record. Since medical records are legal business records it is important that the error corrections standards be followed.

- Initiate a signature sheet/section for the note in the Communicable Disease records such as used on the Immunization records. The signature sheet/section needs to identify the initials and signature and title of each person documenting in the record.

- In the annual documentation refresher training for staff reinforce that all portions of a templated form must be completed even if the area is not applicable to the patient as it is the only way a reviewer can tell if the question was addressed with the patient.

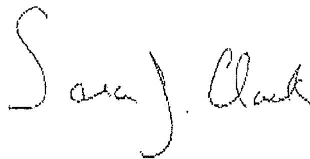
PCS has worked extensively with the New York APG payment methodology since its inception. We have found that certain coding, billing and payment errors are consistently being made by providers. At the same time, DOH and the Managed Care plans have also made payment errors that require providers to resubmit claims. PCS has identified both overpayments and underpayments. Overall, we have found that most providers have opportunities to significantly improve Medicaid APG reimbursement through correcting and resubmitting erroneous claims and improving billing and coding processes. PCS would be happy to assist the county with APG billing questions.

It was a pleasure working with the Ulster County Department of Health on this project, and the assistance and cooperation of the County's staff in facilitating the process and record review is

greatly appreciated. If you have any questions or concerns regarding this report or the attached appendices, please do not hesitate to contact me.

I look forward to the opportunity to continue working with you.

Sincerely yours,



Sara J. Clark, RHIA, MLS
Manager

cc: Nereida Veytia, R.N., M.S.N.
Director of Patient Services
Ulster County Health Department

APPENDIX A
ULSTER COUNTY HEALTH DEPARTMENT
CLINIC FINDINGS

DEPARTMENT: Communicable Disease

Areas of Review:

(1) *Medical Record Forms*: Ensure that entries in the medical record are current, legible, signed and dated by the person making the entry; (10NYCRR, 751.7(f)).

(2) *Master Patient Index*: Ensure that the medical record for each patient contains and centralizes all pertinent information which identifies the patient (10NYCRR, 751.7(d)).

(3) *Medical Record Access*: Ensure that medical, social, personal and financial information relating to each patient is kept confidential and made available only to authorized persons (10NYCRR, 751.7(g)).

(4) *Medical Record Documentation:* Ensure that the following are included in the patient's record as appropriate: patient identification information; consent forms; medical history; immunization and drug history with special notation of allergic or adverse reactions to medications; physical examination reports; diagnostic procedures/tests reports; consultative findings; diagnosis or medical impression; medical orders; psychosocial assessment; documentation of the services provided and referrals made; anesthesia record; progress note(s); follow-up plans; and discharge summaries, when applicable (10NYCRR, 751.7(e)).

(5) *Release of Information:* Ensure that when a patient is treated by an outside health-care provider, and that treatment is relevant to the patient's care, a clinical summary or other pertinent documents are obtained to promote continuity of care. If documents cannot be obtained, the reason is noted in the medical record (10NYCRR, 751.7(h)).

(6) *Record Retention:* Retain medical records for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority whichever time period is longer (10NYCRR, 751.7(j)).

(7) *Confidentiality and Privacy:* Maintain medical records at the center in a safe and secure place which can be locked and which is readily accessible to staff (10NYCRR, 751.7(i)).

FINDINGS:

- In two cases the documentation was not signed or dated.
- Lab results given to patient were initialed not signed with a full name and credential.

RECOMMENDATIONS:

- Review all documentation at the end of the visit to ensure that it is complete.
- Provide refresher training to staff that all documentation in the medical record must be signed and dated by the author.
- Institute a signature sheet for all staff with a printed name, signature, title and initials so staff may initial documentation and still be appropriately identified.
- Please see Appendix B for case specific findings. Items marked with a No means they were not in the record at the time of review.

APPENDIX A
ULSTER COUNTY HEALTH DEPARTMENT
CLINIC FINDINGS

DEPARTMENT: Immunizations

Areas of Review:

(8) *Medical Record Forms*: Ensure that entries in the medical record are current, legible, signed and dated by the person making the entry; (10NYCRR, 751.7(f)).

(9) *Master Patient Index*: Ensure that the medical record for each patient contains and centralizes all pertinent information which identifies the patient (10NYCRR, 751.7(d)).

(10) *Medical Record Access*: Ensure that medical, social, personal and financial information relating to each patient is kept confidential and made available only to authorized persons (10NYCRR, 751.7(g)).

(11) *Medical Record Documentation:* Ensure that the following are included in the patient's record as appropriate: patient identification information; consent forms; medical history; immunization and drug history with special notation of allergic or adverse reactions to medications; physical examination reports; diagnostic procedures/tests reports; consultative findings; diagnosis or medical impression; medical orders; psychosocial assessment; documentation of the services provided and referrals made; anesthesia record; progress note(s); follow-up plans; and discharge summaries, when applicable (10NYCRR, 751.7(e)).

(12) *Release of Information:* Ensure that when a patient is treated by an outside health-care provider, and that treatment is relevant to the patient's care, a clinical summary or other pertinent documents are obtained to promote continuity of care. If documents cannot be obtained, the reason is noted in the medical record (10NYCRR, 751.7(h)).

(13) *Record Retention:* Retain medical records for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority whichever time period is longer (10NYCRR, 751.7(j)).

(14) *Confidentiality and Privacy:* Maintain medical records at the center in a safe and secure place which can be locked and which is readily accessible to staff (10NYCRR, 751.7(i)).

FINDINGS:

- In one case a medical record documentation error was inappropriately corrected.
- In two cases the person documenting in the medical record did not sign their note.

RECOMMENDATIONS:

- Provide refresher training to staff on appropriate procedure for medical record error correction.
- Provide refresher training to staff that all documentation in the medical record must be signed and dated by the author.
- Please see Appendix C for case specific findings. Items marked with a No means they were not in the record at the time of review.

APPENDIX A
ULSTER COUNTY HEALTH DEPARTMENT
CLINIC FINDINGS

DEPARTMENT: WIC

Areas of Review:

(1) *Medical Record Forms*: Ensure that entries in the medical record are current, legible, signed and dated by the person making the entry; (10NYCRR, 751.7(f)).

(2) *Master Patient Index*: Ensure that the medical record for each patient contains and centralizes all pertinent information which identifies the patient (10NYCRR, 751.7(d)).

(3) *Medical Record Access*: Ensure that medical, social, personal and financial information relating to each patient is kept confidential and made available only to authorized persons (10NYCRR, 751.7(g)).

(4) *Medical Record Documentation:* Ensure that the following are included in the patient's record as appropriate: patient identification information; consent forms; medical history; immunization and drug history with special notation of allergic or adverse reactions to medications; physical examination reports; diagnostic procedures/tests reports; consultative findings; diagnosis or medical impression; medical orders; psychosocial assessment; documentation of the services provided and referrals made; anesthesia record; progress note(s); follow-up plans; and discharge summaries, when applicable (10NYCRR, 751.7(e)).

(5) *Release of Information:* Ensure that when a patient is treated by an outside health-care provider, and that treatment is relevant to the patient's care, a clinical summary or other pertinent documents are obtained to promote continuity of care. If documents cannot be obtained, the reason is noted in the medical record (10NYCRR, 751.7(h)).

(6) *Record Retention:* Retain medical records for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority whichever time period is longer (10NYCRR, 751.7(j)).

(7) *Confidentiality and Privacy:* Maintain medical records at the center in a safe and secure place which can be locked and which is readily accessible to staff (10NYCRR, 751.7(i)).

FINDINGS:

- No issues were identified in the record reviewed.

RECOMMENDATIONS:

- Please see Appendix D for case specific findings. Items marked with a No means they were not in the record at the time of review.

APPENDIX A
ULSTER COUNTY HEALTH DEPARTMENT
CLINIC FINDINGS

DEPARTMENT: Tuberculosis Clinic

Areas of Review:

(8) *Medical Record Forms*: Ensure that entries in the medical record are current, legible, signed and dated by the person making the entry; (10NYCRR, 751.7(f)).

(9) *Master Patient Index*: Ensure that the medical record for each patient contains and centralizes all pertinent information which identifies the patient (10NYCRR, 751.7(d)).

(10) *Medical Record Access*: Ensure that medical, social, personal and financial information relating to each patient is kept confidential and made available only to authorized persons (10NYCRR, 751.7(g)).

(11) *Medical Record Documentation:* Ensure that the following are included in the patient's record as appropriate: patient identification information; consent forms; medical history; immunization and drug history with special notation of allergic or adverse reactions to medications; physical examination reports; diagnostic procedures/tests reports; consultative findings; diagnosis or medical impression; medical orders; psychosocial assessment; documentation of the services provided and referrals made; anesthesia record; progress note(s); follow-up plans; and discharge summaries, when applicable (10NYCRR, 751.7(e)).

(12) *Release of Information:* Ensure that when a patient is treated by an outside health-care provider, and that treatment is relevant to the patient's care, a clinical summary or other pertinent documents are obtained to promote continuity of care. If documents cannot be obtained, the reason is noted in the medical record (10NYCRR, 751.7(h)).

(13) *Record Retention:* Retain medical records for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority whichever time period is longer (10NYCRR, 751.7(j)).

(14) *Confidentiality and Privacy:* Maintain medical records at the center in a safe and secure place which can be locked and which is readily accessible to staff (10NYCRR, 751.7(i)).

FINDINGS:

- Templated forms were not always completed so it was not possible to tell if the answer to the question was no or the question was not asked.
  - Current medications were blank in both records though at the time of the visit the patient had started INH treatment.
- Authorization for release of medical information form not completed.
  - Name of patient or type of information to be requested/released was not identified when patient signed form.

RECOMMENDATIONS:

- Complete templated portions of record with none, NKA, etc as appropriate to demonstrate area was reviewed.
- Review release of information form to ensure it is completely filled out when patient signs it.
- Please see Appendix E for case specific findings. Items marked with a No means they were not in the record at the time of review.

Hearing List for December-11 January 9th 2012 BOH Meeting

Facility	What Stage It is In	Type	Informal	A&S Signed		Formal	Hearing		Comments	2nd Formal	Hearing	
	IF or F		Date Scheduled		Comments		Date Scheduled	Time		Did not stay in complance	Date Scheduled	Time
Rainbow Diner	2F	Water								2nd Formal	1/31/2012	10:00 AM
Roundout Bay Café	F	Food		Yes	exceeded going to formal		1/31/2012	2:00 PM				
West Park Wine Cellars	F	Water		Yes	exceeded going to formal	In Process	Pending					
Ace of Clubs	F	Water		Yes	exceeded going to formal	In Process	Pending					
Pesticide Complaint	F	Area				In Process	Pending		$2,500.00			
Kime	F	Area			Rat Infestation	Completed	Settled		$500.00			
Savona's Pizza -father	IF	TempFood	12/19/11	Yes	Fee received 12/19/2011							
Gi Gi Catering	IF	TempFood	12/19/11		did not attend							
Jo Jo Treats	IF	TempFood	12/19/11	No	Fee received 12/1/11							
The Would	IF	TempFood	12/19/11	No	Fee received 12/1/11							
Winnies Jerk Chicken	IF	TempFood	12/19/11	No	Fee received 12/8/11							
Fez	IF	TempFood	12/19/11	Yes	Fee received 12/19/2011							
Whats Poppin Kettle Korn	IF	TempFood	12/19/11	No	Fee received 12/8/11							
Maggy's Melted Munchies	IF	TempFood	12/19/11		did not attend							
The Falcon	IF	TempFood	12/19/11	No	Paid fee							

Hearing List **December 12th 2011 BOH**

Facility	What Stage It is In	Type	Informal	A&S Signed		Formal	Hearing		Comments	2nd Formal	Hearing		Comments
	IF or F		Date Scheduled		Comments		Date Scheduled	Time		Did not stay in compliance	Date Scheduled	Time	
Cherries on Top	2F	Water		Yes	exceeded going to formal	Completed			Going to 2nd	2nd Formal	12/12/2007	10:00 AM	Settled
Rainbow Diner	2F	Water		Yes	exceeded going to formal	Completed			Going to 2nd	2nd Formal			
Ace of Clubs	F	Water		Yes	exceeded going to formal	In Process	May settle out						
West Park Wine Cellars	F	Water		Yes	exceeded going to formal	In Process	12/19/2012	10:00 AM					
Pesticide Complaint	F	Area	None	None	None	In Process	Pending 3,000.00 Fine						3000 dollars
Ireland Corners Gas and Convenience	F	Area	None	None	ATUPA	In Process	11/21/2011	1:00 PM	Completed				
Kime	F	Area	None	None	Rat Infestation	In Process	Rescheduled		UCDOH to do final inspection				
Hurley Recreation Association	IF	Pool	11/16/11										
C Kingston Municipal Day Camp	IF	Child Camp	11/16/11	Yes	A&S signed and returned								
Resort at Accord	IF	Water	11/16/11		A&S mailed								
J &J Concessions	IF	Temp Food	11/22/11		Fee paid prior to hearing								
Pretzel Roll Factory Corp.	IF	Temp Food	11/22/11		Fee paid-bad check								
Panzarells's	IF	Temp Food	11/22/11		Did not attend hearing								
Gaby's Café Corp.	IF	Temp Food	11/22/11		Fee paid prior to hearing								
St. Mary of the Snow School	IF	Temp Food	11/22/11		Late fee/insurance provided								

January BOH
Ulster County Mobile Home Program **2012**

83 Year Round Permitted Facilities

Requirements:

1 inspection per year
Distance between the units for fire safety requirements
Has required and adequate garbage disposal
General Sanitation
Adequate sewage treatment system

57 Facilities that have individual wells and septic systems

All regulation in 5-1 does not apply to state defined systems which are 5-14 service connection or less than 25 people.

All federally defines facilities must meet all requirements of 5- 1. These facilities are considered community water systems and are require to having a class C operator to run the system.

Water supply requirements for federally defined systems

Monthly MOR
Disinfection by products
Lead and copper
Monthly Bacteriological
Annual Nitrates
Period 3 year review of VOC, SOC and IOC (Synthetic, Volatile and Inorganic Organic Chemicals)

Violations

Red items:

Anchoring system of the home
Disposal system is in operation, no sewage on the ground
Disinfection is installed and operating
Park wiring has passed installation standards

Plan Review

Site Plan
Water
Septic

Interesting Items:

- 2011 we had one trailer blow up due to a propane leak. This is an example of why we have minimized separation distances for fire spread.